Arnold Medical Centre

Quality Report

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Date of inspection visit: 13 May 2016
Date of publication: 07/06/2016

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Arnold Medical Centre on 13 May 2016. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed with the exception of those relating to some areas of medicines management.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw two areas of outstanding practice:

Summary of findings

- The practice proactively screened patients at influenza clinics, taking patient pulses to determine whether they were at risk of suffering from atrial fibrillation (a heart condition). Several patients had been identified with the condition in this way.
- The practice reviewed referrals to other services and patient attendances at local accident and emergency services. As a result, the practice had provided appointments with GPs at lunchtimes and had introduced telephone appointments and a triage system run by GPs. We saw evidence that for the period of April 2015 to March 2016 the practice had the lowest patient attendance at the local accident and emergency service in the clinical commissioning group (CCG) and were next to bottom in the CCG for patient emergency hospital admissions.

The areas where the provider must make improvement are:

- Ensure that safe systems, processes and procedures are in place for the management of refrigerated medicines and vaccines.

The areas where the provider should make improvement are:

- Ensure that all Disclosure and Barring Service (DBS) checks are seen or risk assessments carried out before staff are allowed to work in direct contact with patients.
- Ensure that minutes are kept for all clinical staff meetings.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services.

- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safeguarded from abuse. We saw evidence that staff had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). However, the DBS check result for the newest staff member had not been received by the practice and that member of staff was acting as a chaperone.
- Risks to patients were generally assessed and well managed. However, the management of refrigerated medicines and vaccines was poor and systems for recording, handling and storing these medicines were lacking.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average. We saw evidence that for the period of April 2015 to March 2016 the practice had the lowest patient attendance at the local accident and emergency service in the clinical commissioning group (CCG) and were next to bottom in the CCG for patient emergency hospital admissions.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- The practice held regular weekly clinical meetings to carry out such activities as peer review, significant event analysis and to discuss audit results although minutes of these meetings were not always kept.

Summary of findings

- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- The practice was a training practice and had been awarded a quality teaching practice bronze award in 2014-2015 from the University of Manchester.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- The practice was running a one-year pilot of a telehealth system that used electronic reporting of patient health indicators to predict possible future patient health conditions.

Are services caring?

Outstanding 

The practice is rated as outstanding for providing caring services.

Data from the national GP patient survey showed patients rated the practice higher than others for all aspects of care:

- 94% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 82% and the national average of 89%.
- 93% of patients said the GP gave them enough time compared to the CCG and national averages of 87%.
- 94% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 85%.
- 94% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.
- Feedback from patients about their care and treatment was consistently positive.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice was registered with the Royal National Institute for the Blind (RNIB) and had the facility to be able to translate any patient information leaflet into braille if needed. The practice had a guide dog policy in place.

Are services responsive to people's needs?

Good 

The practice is rated as good for providing responsive services.

Summary of findings

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. The practice had identified that there were problems in the area relating to sexual health and offered services in the practice to address this.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had reviewed patient attendances at the local accident and emergency service and as a result, provided patients with a lunchtime surgery as well as morning and afternoon surgeries.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels. The practice had trialled a mobile version of the patient record clinical system for the clinical commissioning group (CCG) and had reported on its findings.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice worked with the local care home team to plan care for older patients and telephoned all patients who had an unplanned hospital admission when they were discharged.
- The practice provided its own clinics for patients who were taking warfarin and needed blood levels to be monitored regularly.
- The practice proactively screened patients at influenza clinics, taking patient pulses to determine whether they were at risk of suffering from atrial fibrillation (a heart condition).

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- Staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was similar to or better than the Clinical Commissioning Group (CCG) and national averages. For example blood measurements for diabetic patients showed that 89% of patients had cholesterol levels at or below the recommended level compared with the CCG average of 85% and national average of 81%.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. The practice offered patients a printed sheet after their health check that listed the results from the check such as blood pressure and cholesterol readings and also offered advice on the areas covered.

Summary of findings

- For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 89% which was better than the CCG average of 81% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses. The community health visitor had worked with the practice for 16 years and provided good continuity of care to patients.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice offered a 'Commuter's Clinic' on a Monday evening until 8.45pm for working patients who could not attend during normal opening hours.
- The practice offered telephone appointments with GPs for those who were unable to attend the practice.
- The use of the practice telehealth machine allowed patients to access equipment to test their own blood pressure, weight, temperature and oxygen saturation levels without an appointment.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice could refer to the homeless team at social services for those needing emergency housing.
- The practice offered longer appointments and open access for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- 85% of patients diagnosed with dementia had their care reviewed in a face-to-face meeting in the last 12 months, which is comparable to the national average of 84%.
- 94% of patients with schizophrenia, bipolar affective disorder and other psychoses had an agreed comprehensive care plan recorded in the last 12 months, which was higher than the CCG average of 93% and the national average of 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. A mental health practitioner visited the practice on most weeks to provide counselling services.
- The practice carried out advance care planning for patients with dementia.
- Women experiencing low moods in the antenatal and postnatal periods were encouraged to join sessions run by the community health visiting team.

Summary of findings

- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 January 2016. The results showed the practice was performing above local and national averages. 352 survey forms were distributed and 122 were returned. This represented 2.7% of the practice's patient list.

- 92% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 88% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 96% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 92% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 13 comment cards which were all positive about the standard of care received. Patients commented that they received an excellent service and that they found the staff both courteous and caring.

We spoke with two patients during the inspection. Both patients said they were very satisfied with the care they received and thought staff were approachable, committed and caring. Both patients told us that they never had any problems in getting an appointment when they wanted one and felt valued by everyone at the practice.

Areas for improvement

Action the service MUST take to improve

- Ensure that safe systems, processes and procedures are in place for the management of refrigerated medicines and vaccines.

Action the service SHOULD take to improve

- Ensure that all Disclosure and Barring Service (DBS) checks are seen or risk assessments carried out before staff are allowed to work in direct contact with patients.
- Ensure that minutes are kept for all clinical staff meetings.

Outstanding practice

- The practice proactively screened patients at influenza clinics, taking patient pulses to determine whether they were at risk of suffering from atrial fibrillation (a heart condition). Several patients had been identified with the condition in this way.
- The practice reviewed referrals to other services and patient attendances at local accident and emergency services. As a result, the practice had provided appointments with GPs at lunchtimes and had introduced telephone appointments and a triage system run by GPs. We saw evidence that for the period of April 2015 to March 2016 the practice had the lowest patient attendance at the local accident and emergency service in the clinical commissioning group (CCG) and were next to bottom in the CCG for patient emergency hospital admissions.

Arnold Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a practice nurse specialist adviser.

Background to Arnold Medical Centre

Arnold Medical Centre is situated in the South Shore area of Blackpool. It is housed in a large detached property with car parking to the rear. The practice provides services to 4486 patients.

The practice is part of the NHS Blackpool Clinical Commissioning Group (CCG) and services are provided under a Personal Medical Services Contract (PMS). There are two GP partners (one male and one female) and one female salaried GP. The practice also employs a pharmacist and a practice nurse. An additional practice nurse has been recruited to start in June 2016. Non-clinical staff consisting of a practice manager and five administrative and reception staff support the practice. The practice is a training practice for medical students and GP trainees at different stages of their learning.

The practice is open between 8am and 6.30pm on Monday to Friday and offers extended opening hours on a Monday until 8.45pm. When the practice is closed, patients are able to access out of hours services offered locally by the provider Fylde Coast Medical Services by telephoning 111.

The practice has a larger proportion of patients aged between 45 and 55 years of age compared to the national average and fewer patients aged between 25 and 40 years of age. There are also more patients aged over 65 on the practice list (21%) than the CCG average of 20% and the national average of 17%.

Information published by Public Health England rates the level of deprivation within the practice population group as two on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice caters for a lower proportion of patients experiencing a long-standing health condition (48% compared to the local average of 63% and national average of 54%). The proportion of patients who are in paid work or full time education is higher (54%) than the CCG average of 52% and lower than the national average of 62% and unemployed figures are lower, 3% compared to the CCG average of 7% and the national average of 5%.

The practice provides level access to the building and is adapted to assist people with mobility problems. The building is on two floors, with the majority of the consulting rooms being on the ground floor. Patients can access the consulting rooms on the first floor by using the stairs and there is a stair lift for those patients who need it.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 13 May 2016. During our visit we:

- Spoke with a range of staff including three GPs, the practice manager, the practice pharmacist, three student GPs, a community health visitor and three members of the practice administrative team.
- Spoke with two patients who used the service.
- Observed how patients were being cared for and talked with carers and family members.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Significant events were also reported to the clinical commissioning group (CCG) on a wider incident reporting system.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, the practice recorded the wrong patient details on a form which went with a cervical smear to the cytology service. This resulted in the cytology service rejecting the test and the patient had to return to the practice to repeat it. The practice gave the patient a full apology, shared details of the error with all staff and introduced a new protocol for cytology tests.

Overview of safety systems and processes

The practice had many clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three and the practice nurse to level two.
- A notice in the waiting room advised patients that chaperones were available if required. There were two non-clinical members of staff who acted as chaperones. Both were trained for the role however the newest staff member had not received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice had already applied for the DBS check and told us that they would do a risk assessment for that staff member to allow them to chaperone until the DBS check was received.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the pharmacist, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- The practice operated a clear desk policy where all patient identifiable information in every room was locked away each night.
- Practice policies and procedures were reviewed regularly and reviews documented in the policies themselves.
- We reviewed three personnel files and found appropriate recruitment checks had been undertaken

prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). We also reviewed the practice file for the locum practice nurse who was working at the time of the inspection. We found a signed letter on non-headed paper from the practice manager of a neighbouring practice confirming that there was a DBS certificate but no copy of that certificate.

- The arrangements for managing non-refrigerated and emergency medicines and vaccines in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal).
- There were two refrigerators in the practice for storage and only one of these had two thermometers for the recording of maximum and minimum temperatures to allow accurate checking. The medicines and vaccines were not segregated between refrigerators and childhood vaccinations were stored alongside travel vaccinations and others such as shingles vaccinations. We found one out of date influenza vaccine in a small cool bag in one of the refrigerators. The refrigerators were also over stocked , not allowing sufficient air to circulate and one refrigerator had evidence of water leakage on the floor. Several vaccines were out of their packaging which did not allow for the recording of batch numbers or checking for expiry dates before use. We saw evidence of checking of refrigerator temperatures however there was evidence of missed checks for both refrigerators principally when the practice nurse was absent. For example for three weeks in January 2016 for one refrigerator and generally two days in every week for the other. We also saw evidence of records for one of the refrigerators that recorded a minimum temperature of zero degrees, once in December 2015, twice in March 2016 and six times in April 2016. When we pointed this out, the practice took immediate action. Staff put a notice on the affected refrigerator indicating that the vaccines and medicines were not to be used and contacted public health England for advice.
- On the day following inspection, the practice introduced a new protocol for checking the temperatures of the refrigerators and a new policy for monitoring refrigerated stock and we saw evidence of this. We were also told that the practice was contacting all patients who had received vaccines that may have been compromised to offer booster vaccinations.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. There were also panic buttons in all rooms that alerted the police when necessary.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room on an emergency trolley.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

Requires improvement

Are services safe?

- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. The practice had also developed its own clinical protocols and procedures that reflected best practice.
- The practice monitored that these guidelines were followed through risk assessments, audits and patient medication reviews.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99.1% of the total number of points available with 9.4% exception reporting (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014-2015 showed:

- Performance for diabetes related indicators was comparable to the local clinical commissioning group (CCG) and national averages. For example the percentage of patients whose last measured total cholesterol was at or below the recommended level was 89% compared to the CCG average of 84% and national average of 81%.
- The percentage of patients with hypertension having regular blood pressure tests who had their blood pressure well controlled was 89%. This was better than the CCG average of 86% and the national average of 84%.
- Performance for mental health related indicators was comparable to or better than the CCG and national averages. For example, 85% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months compared to the CCG average of 85% and the national average of 84%. Also 94% of patients with schizophrenia, bipolar affective disorder and other psychoses had an agreed comprehensive care plan recorded in the last 12 months, higher than the CCG average of 93% and the national average of 88%.

There was evidence of quality improvement including clinical audit.

- There had been eight clinical audits completed in the last year plus many more patient medication audits and reviews. We saw evidence of 38 different medication searches and audits conducted by the pharmacist since November 2015.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research. The practice clinical staff met weekly to discuss and share best practice although minutes of these meetings were not routinely recorded. The practice reviewed referrals to other services and patient attendances at local accident and emergency services. We saw evidence that for the period of April 2015 to March 2016 the practice had the lowest patient attendance at the local accident and emergency service in the clinical commissioning group (CCG) and were next to bottom in the CCG for patient emergency hospital admissions.
- Findings were used by the practice to improve services. For example, recent action taken following a practice audit resulted in new practice guidelines for the management of patients experiencing gout.

Information about patients' outcomes was used to make improvements such as reviewing referrals to hospital services to ensure that all referrals were appropriate. We saw evidence that for the period of April 2015 to March 2016 the practice was third from the bottom in the CCG for patient attendances at hospital outpatient appointments.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

Good

Are services effective?

(for example, treatment is effective)

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff, for example for those reviewing patients with long-term conditions. One of the practice receptionists had recently trained in venepuncture (the taking of blood) and the practice had planned further assessment of competency and mentoring in phlebotomy to enable her to practice.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Student doctors who were training at the practice told us that they received good induction, support and education from the practice. The practice had been awarded a quality teaching practice bronze award in 2014-2015 from the University of Manchester.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. The community health visitor had supplied safeguarding children training to practice staff.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice used the patient clinical record system to add notes for staff to co-ordinate and plan patient treatment when the patient was visiting the practice.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals including the local care home team on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs and vulnerable patients were discussed. Doctors telephoned all vulnerable patients discharged from hospital and those discharged following an unplanned admission.

The practice was part of a local neighbourhood group of practices which met every two months to plan community services. Attendees at these meetings also included representatives from other local patient health and wellbeing services.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

Good

Are services effective?

(for example, treatment is effective)

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- The practice proactively screened patients at influenza clinics, taking patient pulses to determine whether they were at risk of suffering from atrial fibrillation (a heart condition). The practice had identified several patients at risk in this way.
- The practice had recently started a one-year pilot project that provided telehealth health screening for patients. This screening enabled patients to use a special machine in a separate room in the practice that measured several health indicators such as blood pressure, weight, temperature and oxygen saturation levels. Results were then sent electronically to an independent organisation which provided a translation of the readings to the practice. This enabled indicators of possible health conditions to be picked up and managed proactively by the practice.
- The practice's uptake for the cervical screening programme was 89%, which was better than the CCG average of 81% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were better than the CCG average. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 98% to 100% and five year olds from 92% to 100%. The community health visitor had been with the practice for 16 years and provided good continuity of care to patients.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Outstanding ☆

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could direct them to a privacy hatch to discuss their needs in a corridor separate from the waiting area. We saw a notice telling patients about this.

All of the 13 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with two members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Both members said how happy they were to be patients at the practice and that they felt privileged to be registered there. Patients also told us that the GPs often went over and above what was expected of them. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 94% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 82% and the national average of 89%.
- 93% of patients said the GP gave them enough time compared to the CCG and national averages of 87%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG and the national averages of 95%.
- 94% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 85%.
- 96% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 94% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

The practice provided its own clinics for patients who were taking warfarin and needed blood levels to be monitored regularly. This saved the patients having to travel to clinics outside the practice area.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were above local and national averages. For example:

- 88% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG and the national averages of 86%.
- 90% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national averages of 82%.
- 93% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

Outstanding ☆

Are services caring?

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- The practice was registered with the Royal National Institute for the Blind (RNIB) and had the facility to be able to translate any patient information leaflet into braille if needed. The practice had a guide dog policy in place.
- Information leaflets were also available in easy read format if needed.
- The practice offered patients a printed sheet after annual or six-monthly health checks that listed the results from the check such as blood pressure and cholesterol readings in an easy read format which also offered advice on the areas covered.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 97 patients as carers, 2% of the practice list. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP telephoned them and then sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had identified that there were problems in the locality relating to sexual health and offered services in the practice to address this.

- The practice offered a 'Commuter's Clinic' on a Monday evening until 8.45pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. The GPs did both planned and emergency home visits.
- Same day appointments were available for children and those patients with medical problems that required same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities, a hearing loop and translation services available.
- The practice had installed a stair lift to aid access to consulting rooms on the first floor.
- The practice offered dementia screening for those patients who were suffering memory loss and referred to appropriate services if necessary.
- Staff were able to refer to the homeless team at social services if a patient needed emergency housing.
- A mental health practitioner visited the practice on most weeks to provide counselling services.
- GPs encouraged patients experiencing low mood either before or after giving birth to join sessions run by the local health visiting team.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday with extended opening hours on Mondays until 8.45pm. Doctor appointments were from 8am to 7.15pm on Mondays and from 8am to 5.50pm during the rest of the week. Late appointments until 8.35pm with the practice nurse were also offered on Mondays. In addition to pre-bookable appointments that could be booked up to three months in advance, urgent appointments were also available for people that needed them. The practice had between eight and ten emergency appointments each day that could be booked directly by reception staff and then any other requests for urgent appointments were triaged by the GPs. There was a good system in place to ensure that all patients asking for an urgent appointment were either seen or telephoned on the day. Clinicians asked patients needing a repeat appointment with a GP to contact the practice for a telephone appointment initially. This helped to free up face-to-face appointments.

The practice had reviewed patient attendances at the local accident and emergency service and had determined that patients often visited the service when there were no surgeries in the practice at lunchtime. The practice then changed GP surgeries to give patients access to a lunchtime surgery as well as morning and afternoon surgeries.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was higher than local and national averages.

- 89% of patients were satisfied with the practice's opening hours compared to the CCG average of 86% and the national average of 78%.
- 92% of patients said they could get through easily to the practice by phone compared to the CCG average of 78% and the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them. We were told that it was usual that the next routine appointment available with a GP was on the following day and we saw this on the day of inspection. Patients told us that if they wanted a particular GP they sometimes had to wait but that it was usually only for a few days at most.

The practice had a system in place to assess:

- whether a home visit was clinically necessary.
- the urgency of the need for medical attention.

Staff recorded patient requests for home visits and the reason for the request and the GPs telephoned the patient to assess the need for a visit and the urgency of that need. In cases where the urgency of need was so great that it

Good

Are services responsive to people's needs?

(for example, to feedback?)

would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person, the practice manager, who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. There was a notice in the waiting room and a leaflet available in reception telling patients how to complain.

We looked at six complaints received in the last 12 months and found that they were dealt with in a timely way and with openness and empathy. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, following a complaint by a patient regarding the attitude of a member of staff, the staff member reflected on practice and wrote to the patient apologising and expressing empathy.

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which was displayed on the practice website and staff knew and understood the values.
- The practice had a comprehensive strategy and supporting business plans which reflected the vision and values and were regularly monitored. The practice had produced a forward planning document that set out the practice plans for one, three and five years' time. The GP partners had purchased the practice premises in October 2015 and had a refurbishment plan for the building.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were generally good, however in the area of medicines management, systems to manage refrigerated medicines and vaccines were lacking.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. Staff had all received customer care training in the last year. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings. There were whole practice meetings and reception staff meetings usually every month.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted that the practice provided at least one social event for staff every year. Many staff had been with the practice for some time, one member of staff for 22 years.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

proposals for improvements to the practice management team. For example, as a result of a patient survey, the practice changed the telephone system and redecorated the waiting area.

- The practice had gathered feedback from staff generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example, the security of the practice was under review following an incident in the practice one evening involving an irate patient. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice had trialled a mobile version of the patient record clinical system for the clinical commissioning group (CCG) and had reported on its findings. The practice had recently began a one-year pilot of a telehealth system that used electronic reporting of patient health indicators to predict possible future patient health conditions.

The practice was part of a local neighbourhood group of practices which met every two months to plan community services. Current planning involved training members of the district nursing service to manage patients in the community who suffered from hypertension.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. There were shortfalls in ensuring that systems, processes and procedures were in place and adhered to for the recording and storing of refrigerated medicines and vaccines. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.